

EXHIBIT 1

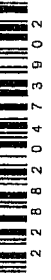
Provider/Type of Service	Service Date(s)	Charge(s) Submitted	Amount Not Covered	Amount Covered	Patient Deductible	Patient Copay	Covered Balance	Coinsurance	Total Plan Benefit	Remark Cod
MELVIN KAPLAN OBSTETRICIAN MEDICAL SERVICES	DATE RCVD: 08/29/06 08/15/2006 08/15/2006	100.00 100.00	50.00 50.00	0.00 0.00	0.00 0.00	0.00 0.00	0.00 0.00	0.00 0.00	0.00 0.00	UC2 039 047
TOTALS										

Medical Accumulation Information

Benefit Period: 01/01/2006 to: 12/31/2006	In-Network	Out-of-Network
Individual Deductible Satisfied:	-----	300.00
Family Deductible Satisfied:	-----	750.00
Individual Out-of-Pocket to Date:	-----	1500.00
Family Out-of-Pocket to Date:	-----	3249.00
Individual Life-Time Maximum Paid to Date:	-----	19700.62
Portion of this Statement Paid by Other Insurance:	0.00	
Insurance Portion Paid by your CIGNA benefits:	0.00	
Patient Responsibility:	100.00	

Explanation of Remarks

UC2 MAXIMUM REIMBURSABLE RATE USED, IF APPLICABLE, MEMBER RESPONSIBILITY IS CHARGED AMOUNT MINUS TOTAL PLAN BENEFIT. PROVIDER MAY BALANCE BILL YOU.
039 MEMBER UNIT LIMIT EXCEEDED.
047 THIS MEMBER HAS EXCEEDED THEIR OUT-OF-POCKET MAXIMUM FOR THIS PLAN YEAR.



EX.